

REQUEST FOR SPECIALIZED TRANSPORTATION TO/FROM SCHOOL

NEW UPDATE TO EXISTING SERVICES
 SPECIAL ED RELATED SERVICES ACADEMIC 504 MEDICAL 504
 PRATT CENTER: AM CLASS PM CLASS HEADSTART

STUDENT INFORMATION		
Student's Name:	Age:	Date of Birth:
Height: _____ Weight _____ <i>(Required only if Star Seat or Safety Vest marked below)</i>		
School Location(s): <i>please list the school(s) to which the student is assigned to attend class</i>		
TRANSPORTATION INFORMATION		
Pick Up Location to Transport TO School:	Drop Off Location AFTER School:	
Travel Needs:	<input type="checkbox"/> Walk Assist	<input type="checkbox"/> Car Seat
<input type="checkbox"/> Safety Vest	<input type="checkbox"/> Mobility Assitant	<input type="checkbox"/> Wheelchair
Other (Describe):		
Special Education Transportation Instructions (subject to approval):		
<input type="checkbox"/>	Supervision not required. Student will drop/pick up at nearest bus stop. Student may depart the bus without an adult present.	
<input type="checkbox"/>	Supervision not required. Student must be dropped/picked up at residence. Student may depart the bus without an adult present.	
<input type="checkbox"/>	Supervision required. Student will drop/pick up at nearest bus stop. Student will not be released without parent/guardian present.	
<input type="checkbox"/>	Supervision required. Student must be dropped/picked up at residence. Parent/guardian will retrieve student from the bus.	
HEALTH INFORMATION		
See Emergency Health Care Plan : <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes please attach to reverse)</i>		
Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No Does the student self administer medication: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical staff transported with student: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Student Communication and/or Behavioral Difficulties (please include recommended strategies for de-escalation/avoiding behavior):		
Additional information for assistance in providing Transportation services:		
Referring Staff Member (please print):	Date Submitted:	
	Email:	
	Phone Ext:	
TRANSPORTATION OFFICE USE ONLY		
Transportation Director Approval:	Date Assigned:	
	Start Date:	